ST-FU FOLLOW-UP

OUTCOME: The patient will understand the importance of adherence to the treatment regimen and keeping appointments for follow-up.

STANDARDS:

1. Discuss the patient's responsibility in the treatment of the strep throat.

2. Explain the procedure for making follow-up appointments.

3. Review the treatment plan with the patient and family, emphasizing the need for follow-up appointment and medication compliance.

ST-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about strep throat.

STANDARDS:

1. Provide patient/family with written patient information literature on strep throat.

2. Discuss the content of patient information literature with the patient/family.

ST-M MEDICATIONS

OUTCOME: The patient will have an understanding of the importance of following the prescribed medication regimen.

STANDARDS:

1. Review proper use, benefit and common side effects of the prescribed medication.

2. Emphasis the importance of maintaining strict adherence to the medication regime, i.e. take all the medication even if the symptoms are no longer present.

3. Explain that failure to complete the entire course of antibiotics increases the patient's risk of developing rheumatic heart disease and rheumatic fever as well as the risk of developing resistant bacteria.

ST-P PREVENTION

OUTCOME: The patient/family will understand the measures necessary to prevent the spread of strep throat.

STANDARDS:

1. Explain the importance of good hygiene and infection control principles to prevent the spread of strep infection.

2. Stress the importance of good hand washing.

ST-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand some ways to control pain associated with strep throat.

STANDARDS:

1. Discuss pain management techniques with the patient/family, i.e. gargling salt water, throat lozenges, and other medications as appropriate.

ST-TE TEST

OUTCOME: The patient will have an understanding of the test to be performed and the reason for testing.

STANDARDS:

1. Explain the test used to diagnose strep throat, i.e. throat culture or rapid strep test.

2. Explain the indications and benefits of the test.

3. Explain the test as it relates to the diagnosis and treatment of strep throat.

SB-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

SB-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about suicidal behavior.

STANDARDS:

1. Provide the patient/family with written patient information literature on suicidal behavior.
2. Discuss the content of patient information literature with the patient/family.

SB-PSY PSYCHOTHERAPY

OUTCOME: The patient will understand the goals and process of such therapy.

STANDARDS:

1. Emphasize that for the process of psychotherapy to be effective the patient mustkeep all appointments. Emphasize the importance of openness and honesty with the therapist.
2. Explain to the patient/family that the therapist and the patient will jointly establish goals, ground rules, and duration of therapy.

SB-TX TREATMENT

OUTCOME: The patient/family will have a basic understanding of the short and long term goals and expected result of treatment.

STANDARDS:

1. Reassure the patient. Reinforce the fact that the patient is not alone and that he/she can be helped.
2. Discuss options for treatment, both short-term and long-term.
3. Discuss that there may be an initial crisis stabilization period followed by a longer period of psychotherapy and lifestyle adjustments.

SB-WL WELLNESS

OUTCOME: The patient/family will understand some of the factors which contribute to a balanced and healthy lifestyle.

STANDARDS:

1. Explain that a healthy diet is an important component of behavioral and emotional health. See **WL-N.**

2. Emphasize the importance of stress reduction and exercise in behavioral and emotional health.

3. Explain that behavior and emotional problems often result from unhealthy patterns of social interaction. Help to identify supportive social networks.

4. Emphasize that use of alcohol and/or other drugs of abuse can be extremely harmful to behavioral and emotional health. See **CD.**

5. Emphasize that behavioral and emotional problems often co-exist with domestic violence. Encourage the patient to use local resources as appropriate. See **DV.**

6. Explain other ways the patient can help him/herself feel better.
   a. Talk to someone you trust.

   b. Try to figure out the cause of your worries.

   c. Understanding your feelings will help you see other ways for delaing with your anger or depression.

   d. Write down a list of good things you have done. Remember them and even read the list out loud to yourself when you feel bad.

   e. Do not keep to yourself; be with other people that support and encourage you as much as possible.

   f. **In an emergency or during a crisis call 9-1-1** or other emergency access numbers or crisis hotlines.

SPE-C COMPLICATIONS

OUTCOME: The patient/family will have an understanding of the common and important complications of the proposed procedure.

STANDARDS:

1. Discuss the common and important complications of the proposed procedure.

2. Discuss alternatives to the proposed procedure.

SPE-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to make and keep follow-up appointments.

STANDARDS:

1. Emphasize the importance of follow-up care.

2. Explain the procedure for obtaining appointments.

SPE-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about the surgical procedure or endoscopy.

STANDARDS:

1. Provide the patient/family with written patient information literature on the surgical procedure or endoscopy.

2. Discuss the content of the patient information literature with the patient/family.

SPE-PM PAIN MANAGEMENT

OUTCOME: The patient/family will have an understanding of the plan for pain management.

STANDARDS:

1. Explain that pain management is specific to the disease process of this particular diagnosis and patient and may be multifaceted. **See PM**

2. Explain that short term use of narcotics may be helpful in pain management as appropriate.

3. Explain that other medications may be helpful to control the symptoms of pain.

4. Explain that administration of fluids may be helpful with pain relief and resolution of symptoms.

5. Discuss non-pharmacologic measures that may be helpful with pain control.

SPE-PO POSTOPERATIVE

OUTCOME: Patient and/or family will be knowledgeable about the post-operative course and home management as appropriate.

STANDARDS:

1. Review post-op routine.

2. Discuss symptoms of complications.

3. Review plan for pain management.

4. Discuss home management plan in detail, including signs or symptoms which should prompt re-evaluation.

5. Emphasize the importance of compliance with the plan for follow-up care.

SPE-PR PREOPERATIVE

OUTCOME: Patient/family will be prepared for surgery or other procedure.

STANDARDS:

1. Explain pre-operative preparation, including bathing, bowel preps, diet instructions, etc.

2. Explain the proposed surgery or other procedure including anatomy and physiology, alteration in function, risks, benefits, etc.

3. Discuss common or potentially serious complications.

4. Explain the usual pre-operative routine for the patient's procedure.

5. Discuss what to expect after the procedure.

6. Discuss pain management.

SPE-WC WOUND CARE

OUTCOME: The patient/family will have an understanding of the necessity and procedure for proper wound care. As appropriate they will demonstrate the necessary wound care techniques.

STANDARDS:

1. Explain the reasons to care appropriately for the wound; decreased infection rate, improved healing, etc.

2. Explain the correct procedure for caring for this patient's wound.

3. Explain signs or symptoms that should prompt immediate follow-up; increasing redness, purulent discharge, fever, increased swelling/pain, etc.

4. Detail the supplies necessary for the care of this wound (if any) and how/where they might be obtained.

5. Emphasize the importance of follow-up.

TO-C COMPLICATIONS

OUTCOME: The patient/family will understand how to avoid the slow progression of disease and disability resulting from tobacco use.

STANDARDS:

1. Discuss the common problems associated with tobacco use and the long term effects of continued use of tobacco.(i.e. COPD, cardiovascular disease, numerous kinds of cancers including lung cancer, etc.).

2. Review the effects of tobacco use on all family members- financial burden, second-hand smoke, greater risk of fire, early death of a bread-winner.

TO-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the slow progression of disease and disability associated with tobacco use.

STANDARDS:

1. Review the current factual information regarding tobacco use. Explain that tobacco use in any form is dangerous.

2. Explain nicotine addiction.

3. Explain dependency and co-dependency.

TO-EX EXERCISE

OUTCOME: The patient/family will understand the role of an exercise program as part of rehabilitation and maintenance of tobacco abstinence.

STANDARDS:

1. Review the benefits of regular exercise i.e, reduced stress, weight control, increased self-esteem and overall sense of wellness.

2. Refer to **WL-EX**.

TO-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.

2. Discuss the procedure for obtaining follow-up appointments.

3. Emphasize that appointments should be kept.

TO-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about tobacco use or cessation of use.

STANDARDS:

1. Provide the patient/family with written patient information literature on tobacco use or cessation of use.

2. Discuss the content of the patient information literature with the patient/family.

TO-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will see tobacco abstinence as a way of life.

STANDARDS:

1. Discuss the patient's use/abuse of tobacco.

2. Discuss tips for stress relief and healthy "replacement habits".

TO-M MEDICATIONS

OUTCOME: If applicable, the patient/family will understand the importance of complying with a prescribed medication regimen.

STANDARDS:

1. Review the proper use, benefits and common side effects of the prescribed medication.

2. Briefly review the mechanism of action of the medication if appropriate.

3. Explain that medications can help only if the patient is ready to quit and that medications work best in conjunction with counseling and lifestyle-modification education.

4. Explain that some medications may not work right away but will require a few days to a few weeks to take effect.

5. Emphasize that there may be dangers in using medications in conjunction with smoking and that some medications may be addictive, so it is important to have a dose-tapering regimen and adhere to it.

TO-QT QUIT

OUTCOME: The patient/family will understand that smoking is a serious threat to their health, that they have been advised by health professionals to quit, and how participation in a support program may prevent relapse.

STANDARDS:

1. Discuss the importance of quitting tobacco use now and completely.

2. Establish a quit date and plan of care.

3. Review the treatment and support options available to the patient and family.

4. Review the value of close F/U and support during the first months of cessation.

TO-SHS SECOND-HAND SMOKE

OUTCOME: Provide the patient and/or family with an understanding of the adverse health consequences associated with exposure to second-hand tobacco smoke, and to discuss methods for limiting exposure of nonsmokers to tobacco smoke.

STANDARDS:

1. Define "passive smoking", ways in which exposure occurs:
   a. smoldering cigarette, cigar, or pipe
   b. smoke that is exhaled from active smoker
   c. smoke residue on clothing, upholstery, carpets or walls

2. Discuss harmful substances in smoke
   a. nicotine
   b. benzene
   c. carbon monoxide
   d. many other carcinogens (cancer causing substances)

3. Explain the increased risk of illness in people who are exposed to cigarette smoke either directly or via second-hand smoke. Explain that this risk is even higher for people with pulmonary diseases like COPD or asthma.

4. Explain that cigarette smoke gets trapped in carpets, upholstery, and clothing and still increases the risk of illness even if the patient is not in the room at the time that the smoking occurs.

5. Discuss factors that increase level of exposure to second-hand smoke and preventive methods for minimizing this exposure.

6. Encourage smoking cessation or at least never smoking in the home or car.

TB-DOT DIRECTLY OBSERVED THERAPY

OUTCOME: The patient and family will understand the importance of complying with a prescribed medication regimen using the directly observed therapy (DOT) regimen for TB.

STANDARDS:

1. Provide a pill count.
2. Discuss the use, benefits, and common side effects of prescribed medications.
3. Discuss the patient's compliance/non-compliance. Discuss the consequences of non-compliance.
4. Discuss the procedure for DOT.

TB-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the etiology, pathophysiology, and communicability of tuberculosis infection.

STANDARDS:

1. Review the anatomy and physiology of the affected system (respiratory, lymphatic, etc.).
2. Review hygiene and infection control as it relates to TB.
3. Explain the patient's specific disease process.
4. Explain the most common complications of the disease process.

TB-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

TB-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about tuberculosis.

STANDARDS:

1. Provide the patient/family with written patient information literature on tuberculosis.

2. Discuss the content of the patient information literature with the patient/family.

TB-M MEDICATIONS

OUTCOME: The patient/family will understand the medication regimen and the importance of compliance.

STANDARDS:

1. Discuss the use, benefits, and common side effects of prescribed medications.

2. Emphasize the importance of compliance and completion of therapy. Explain that drug resistance is increased by incomplete courses of therapy.

3. Discuss the consequences of non-compliance.

TB-P PREVENTION

OUTCOME: The patient/family will understand communicability and preventive measures for TB.

STANDARDS:

1. Emphasize the importance of early detection and treatment of TB.

2. Discuss the mode of transmission and methods for reducing the risk of contracting TB (handwashing, covering the mouth when coughing or sneezing, disposing of contaminated materials, etc.).

3. Explain that patients with active TB must wear a mask until they have completed at least two weeks of treatment.

4. Review the actions to take when exposed to TB.

TB-PPD SCREENING SKIN TEST

OUTCOME: Patient/family will understand the importance of screening and follow-up and the meaning of the result.

STANDARDS:

1. Discuss the purpose, procedure, and meaning of the screening test and results if available.

2. Emphasize the importance of screening annually or on other schedule as appropriate.

3. Explain that a person who has reacted positively in the past will always react positively in the future and repeat testing may not be appropriate, or other types of testing may be indicated.

UC-C COMPLICATIONS

OUTCOME: The patient/family will understand the signs of complications of ulcerative colitis and will plan to return for medical care if they occur.

STANDARDS:

1. Explain that some possible complications of ulcerative colitis are colon perforation, hemorrhage, toxic megacolon, abscess formation, stricture, anal fistula, malnutrition,, anemia, electrolyte imbalance, skin ulceration, arthritis, ankylosing spondylitis, and cancer of the colon.

2. Explain that complications may be delayed, minimized or prevented with prompt treatment of exacerbation.

3. Discuss the symptoms of exacerbation that trigger the need to seek medical attention, i.e. unusual abdominal pain, blood in stools, fever, weight loss, change in frequency of stools, joint pain.

UC-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pathophysiology and symptoms of their specific bowel disease.

STANDARDS:

1. Explain that ulcerative colitis is an inflammatory disease of the mucosa and, less frequently, the submucosa of the colon and rectum.

2. Explain that the exact cause of ulcerative colitis is unknown, but may be related to infection, stress, allergy, autoimmunity and familial predisposition.

3. Explain that this disease is most common during young-adulthood to middle life.

4. Explain that the symptoms are diarrhea, abdominal cramping, weight loss, anorexia, nausea, vomiting and abdominal pain.

5. Explain that ulcerative colitis is characterized by remissions and exacerbations.

6. Explain that careful medical management may eliminate/postpone the need for surgical intervention.

UC-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.

2. Discuss the procedure for obtaining follow-up appointments.

3. Emphasize that appointments should be kept.

UC-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about the specific bowel disease.

STANDARDS:

1. Provide the patient/family with written patient information literature regarding colon disease.

2. Discuss the content of the patient information literature with the patient/family.

UC-M MEDICATIONS

OUTCOME: The patient/family will understand the prescribed medication regimen and its importance.

STANDARDS:

1. Describe the proper use, benefits, and common or important side effects of the patient's medications. State the name, dose, and time for administration as applicable.

2. Discuss any significant drug/drug or drug/food interactions, including interaction with alcohol.

3. Discuss with the patient/family the need to complete the full course of antibiotics, as prescribed.

4. Caution the patient/family against utilizing over-the-counter medications for constipation without consulting his/her provider.

UC-N NUTRITION

OUTCOME: The patient/family will have an understanding of how dietary modification may assist in the control of bowel function and develop an appropriate plan for dietary modification.

STANDARDS:

1. Assess current nutritional habits.

2. Advise the patient to avoid dairy products if the patient is lactose intolerant.

3. Encourage the patient/family to maintain a well-balanced, low-residue, high-protein diet.

4. Assist the patient/family to identify foods which cause irritation and encourage them to eliminate or minimize these in the diet.

5. Advise the patient to avoid cold or carbonated foods or drinks which increase intestinal motility.

6. Assist the patient/family in developing appropriate meal plans. Encourage frequent, small meals and chew food thoroughly.

7. Explain that supplementation with vitamins and minerals may be necessary.

8. Refer to dietitian as appropriate.

UC-PM PAIN MANAGEMENT

OUTCOME: The patient/family will have an understanding of the plan for pain management.

STANDARDS:

1. Discuss the plan for sedatives and tranquilizers to provide, not only for rest, but to decrease peristalsis and subsequent cramping.

2. Instruct the patient in careful cleansing and protection of the perianal skin to provide comfort and prevent painful excoriation.

3. Explain that short term use of narcotics may be helpful in acute pain management

4. Advise the patient not to use over the counter pain medications without checking with his/her provider

UC-P PREVENTION

OUTCOME: The patient/family will understand and make a plan for the prevention of colon disease.

STANDARDS:

1. Discuss the effects of a fatty, low fiber diet on the colon.

2. Provide and review a list of low fat, high fiber foods.

3. Assist the patient/family in meal planning that includes low fat, high fiber foods and avoids high fat, low fiber foods.

4. Explain that the etiology of Crohn's disease is unknown and there is no known prevention, but an appropriate diet may prevent or slow progression of the disease.

UC-TE TESTS

OUTCOME: The patient/family will have an understanding of the tests to be performed.

STANDARDS:

1. Proctosigmoidoscopy and Colonoscopy
   a. Explain that proctosigmoidoscopy and colonoscopy may be utilized to directly visualize the inside of the colon and enable biopsies to be obtained. The information from the colonoscopy may be necessary to diagnose the specific type of bowel disease.
   b. Explain that the procedure involves introducing a flexible tube through the anus and rectum.
   c. Explain that the preparation for the test is usually a liquid diet, cathartics and enemas.

2. Upper gastrointestinal barium studies
   a. Explain that the upper GI barium study is an x-ray to assess the degree and extent of the disease.
   b. Explain that barium liquid will be swallowed and radiographs taken.

3. Barium Enema
   a. Explain that the barium enema is an x-ray to assess the extent of the disease, identify lesions, detect pseudo polyps, carcinoma, and strictures.
   b. Explain that barium liquid will be introduced by enema and radiographs taken.
   c. Explain that the preparation for the test is usually a liquid diet, cathartics and enemas.

UC-TX TREATMENT

OUTCOME: The patient/family will have an understanding of the appropriate treatment for ulcerative colitis and verbalize a plan to adhere to the treatment regimen. The patient/family will further understand the risk/benefit ratio of the testing proposed as well as alternatives to testing and the risk of non-testing.

STANDARDS:

1. Discuss the specific treatment plan, which may include the following:
    a. Bedrest
    b. IV fluid replacement to correct dehydration
    c. Clear liquid diet, or in severe cases, parenteral hyperalimentation to rest the intestinal tract and restore nitrogen balance
    d. Sulfasalazine, for its antibacterial and anti-inflammatory effects
    e. Corticosteroids, systemically or by rectal instillation, to decrease inflammation
    f. Colectomy

2. Discuss the risk/benefit ratio and alternatives to treatment as well as the risk of non-treatment.

PATIENT EDUCATION PROTOCOLS: UPPER RESPIRATORY INFECTION

URI-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pathophysiology and symptoms of an upper respiratory tract infection.

STANDARDS:

1. Explain that URIs (colds) are caused by viruses and that anitbiotics are not effective.

2. Discuss the basic anatomy of the upper respiratory system.

3. Discuss the factors that increase the risk for acquiring an upper respiratory infection, i.e. direct physical contact, children in school, etc.

4. Discuss signs and symptoms of an upper respiratory infection, i.e. malaise, rhinorrhea, sneezing, scratchy throat, etc.

URI-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up if needed.

STANDARDS:

1. Discuss the importance of follow-up care, if needed. Explain that follow-up is usually only necessary if symptoms persist for greater than 2 weeks or if symptoms worsen.

2. Discuss the process for obtaining follow-up care and or appointment.

3. Emphasize that appointments should be kept.

URI-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand how to manage an upper respiratory infection at home.

STANDARDS:

1. Discuss the use of over the counter medications for symptom relief i.e. decongestants, antihistamines, expectorants, etc.

2. Discuss the use of non-pharmacologic therapies that may be useful in symptom relief i.e. nasal lavage, humidification of room, increasing oral fluids, etc.

URI-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about upper respiratory infections.

STANDARDS:

1. Provide patient/family with written patient information literature on upper respiratory infection.

2. Discuss the content of patient information literature with the patient/family.

URI-M MEDICATIONS

OUTCOME: The patient/family will understand that antibiotics do not cure viral infections, and understand that some over-the-counter medications may be helpful in symptom reduction.

STANDARDS:

1. Discuss the use of over the counter medications, vitamin supplements and herbal remedies for symptom relief i.e. decongestants, antihistamines, expectorants, etc.

2. Explain that URIs (colds) are caused by viruses and that anitbiotics are not effective.

URI-P PREVENTION

OUTCOME: The patient/family will have an understanding how to reduce the transmission of the common cold.

STANDARDS:

1. Discuss infection control measures, i.e. handwashing, reducing finger-to-nose contact, limiting exposure to the cold sufferer, proper handling and/or disposal of contaminated items.

UTI-DP DISEASE PROCESS

OUTCOME: The patient and family will have a basic understanding of the pathophysiology and symptoms of a urinary tract infection

STANDARDS:

1. Discuss the basic anatomy and physiology of the urinary tract.

2. Discuss factors that increase the risk for developing a urinary tract infection, i.e. bladder outlet obstruction, hygiene factors, pelvic relaxation.

3. Discuss some signs and symptoms of urinary tract infection, i.e. dysuria, frequency, nocturia.

UTI-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care, including test of cure as appropriate.

2. Discuss the procedure for obtaining follow-up appointments

3. Emphasize that appointments should be kept.

UTI-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about urinary tract infections.

STANDARDS:

1. Provide patient/family with written patient information literature.

2. Discuss the content of the patient information literature with the patient/family.

UTI-M MEDICATION

OUTCOME: The patient and family will verbally summarize their medication regimen and the importance of compliance with therapy.

STANDARDS:

1. Review proper use, benefits and common side effects of prescribed medications. Refer to **M**.

2. Discuss importance of compliance with the medication regimen in order to promote healing and assure optimal comfort levels.

3. Discuss the importance of completing the entire course of antibiotics to decrease the risk of development of resistant organisms.

4. Inform patient and family that kidney damage is irreversible and special care needs to be taken to reduce the risk of recurrent infections.

UTI-N NUTRITION

OUTCOME: The patient and family will understand the importance of a nutritionally balanced diet as related to UTI's.

STANDARDS:

1. Assess current nutritional habits and needs.

2. Emphasize the necessary component - WATER - in a healthy diet. Decrease consumption of colas and caffeinated beverages.

UTI-P PREVENTION

OUTCOME: The patient/family will have an understanding of precipitating factors for UTIs and will make a plan to minimize recurrence.

STANDARDS:

1. Discuss importance of adherence to treatment plan.

2. Discuss the role of good hygiene in reducing the risk of UTIs.

3. Discuss the role of prophylactic medications in reduction of future UTIs as indicated.

4. Discuss other lifestyle factors that may help prevent UTIs, i.e. frequent urination, void after sexual intercourse, monogamy, drink plenty of water, eliminate bubble baths.

UTI-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the plan for pain managment.

STANDARDS:

1. Explain that pain management is specific to the disease process of this particular diagnosis and patient and may be multifaceted. **See PM**

2. Explain that medications may be helpful to control the symptoms of pain, nausea and vomiting as applicable.

3. Explain that administration of fluids may be helpful with pain relief and resolution of symptoms.

4. Explain non-pharmacologic measures that may be helpful with pain control.

UTI-TE TESTS

OUTCOME: The patient and family will have basic understanding of the tests to be performed including indications, risks, benefits and consequences of non-intervention.

STANDARDS:

1. Explain the test ordered including indication(s), risks, benefits, information to be obtained and consequences of non-intervention.

2. Explain that the treatment decision will be made by the patient and medical team after reviewing the results of the diagnostic tests.

3. Explain any preparation that must be done prior to testing, i.e. NPO, have a full bladder, void prior to test.

WL-EX EXERCISE

OUTCOME: The patient will relate exercise and/or physical fitness to health promotion and disease prevention.

STANDARDS:

1. Review the benefits of regular exercise.

2. Discuss the three types of exercise: aerobic, flexibility, and endurance.

3. Review the basic recommendations of any exercise program:
   a. If any chronic health problems exist, consult with a health care provider.
   b. Start out slowly.
   c. Exercise a minimum of three times a week.

4. Review the exercise programs available in the community.

WL-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up care and develop a plan to make appointments as appropriate.

STANDARDS:

1. Emphasize the importance of follow-up care.

2. Review the procedure for obtaining follow-up care.

3. Emphasize the importance of keeping appointments.

WL-HY HYGIENE

OUTCOME: The patient will recognize personal routine hygiene as an important part of wellness.

STANDARDS:

1. Review bathing habits, paying special attention to face, pubic hair area and feet. Discuss hygiene as part of a positive self image.

2. Review the importance of daily dental hygiene, with attention to brushing and flossing.

3. Discuss the importance of hand-washing in infection control especially in relationship to food preparation/consumption, child care and toilet use.

4. Discuss the importance of covering the mouth when coughing or sneezing.

5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

WL-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about wellness.

STANDARDS:

1. Provide the patient/family written information about wellness.

2. Discuss the content of the written information with the patient/family.

WL-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient will be able to explain at least one lifestyle change necessary to improve mental or physical health.

STANDARDS:

1. Review the concept that health or wellness refers to the whole person (mind, body and spirit) and is a positive state of health which results from appropriate habits and lifestyle.

2. Review lifestyle aspects/changes that the patient has control over - diet, exercise, safety and injury prevention, and avoidance of high risk behaviors (e.g. smoking, alcohol and substance abuse, sex with multiple partners).

3. Discuss wellness as an individual responsibility to:
   a. Learn how to be healthy.
   b. Be willing to change.
   c. Practice new knowledge.
   d. Get help when necessary.

4. Review the community resources available for help in achieving behavior changes.

WL-N NUTRITION

OUTCOME: The patient will relate diet to health promotion and disease prevention.

STANDARDS:

1. Assess current nutritional habits.

2. Discuss the importance of the food pyramid.

3. Review the relationship of calories to energy balance and body weight.

4. Emphasize the importance of limiting snack foods, fatty foods, red meats, reducing sodium consumption and adding more fresh fruits, fresh vegetables, and fiber to the diet.

5. Emphasize the necessary component —WATER— in a healthy diet. Reduce the use of colas, coffee and alcohol.

6. Review which community resources exist to assist with diet modification and weight control.

7. Stress the importance of being a smart shopper.

WL-S SAFETY AND INJURY PREVENTION

OUTCOME: The patient will be able to identify at least one way to reduce injury risk.

STANDARDS:

1. Discuss the regular use of seat belts and children's car seats, obeying the speed limit, and avoiding the use of alcohol while in a vehicle.

2. Discuss poison prevention: i.e., proper storage and safe use of medicines, cleaners, auto products, paints, etc.

3. Discuss proper use of ipecac syrup.

4. Review the dangers inherent in the use of wood-burning stoves, "charcoal pans", kerosene heaters, and other open flames.

5. Review the safe use of electricity and gas.

6. Discuss the proper disposal of waste, including sharps and hazardous materials.

7. Review the proper handling, storage and preparation of food.

8. Review the importance of uncontaminated water sources. Discuss the importance of purifying any suspect water by boiling or chemical purification.

9. Identify which community resources promote safety and injury prevention. Provide information regarding key contacts for emergencies, e.g., 911, Poison Control, hospital ER, police.

WL-SCR SCREENING

OUTCOME: The patient/family will understand the proposed screening test including indications.

STANDARDS:

1. Discuss the indication, risks, and benefits for the proposed screening test. (guaiac, blood pressure, hearing, vision, development, mental health, etc.).

2. Explain the process and what to expect after the test.

3. Emphasize the importance of follow-up care.

WL-SX SEXUALITY

OUTCOME: The patient will have an understanding of how sexuality relates to wellness.

STANDARDS:

1. Review sexuality as an integral part of emotional and physical health.

2. Discuss how sexual feelings play a part in each person's personal identity.

3. Discuss sexual feelings as an important part of interpersonal relationships.

4. Discuss how sexuality varies with gender, age, life-stage, and relationship status.

5. Explain the preventive measures for STDs (refer to **STD-P**).

6. Review the community resources available for sexual counseling or examination.

WH-BE BREAST EXAM

OUTCOME: The patient will understand the importance of monthly breast self-examination, annual clinical breast exam, and mammograms as appropriate.

STANDARDS:

1. Discuss breast anatomy and the normal changes that occur with pregnancy, menstruation and age.

2. Explain that fibrocystic changes of the breast are a normal finding and become more common with increasing age. Explain that fibrocystic changes may be exacerbated by intake of caffeine.

3. Emphasize the importance of monthly examination in early detection of breast cancer. Survival rates are markedly higher when cancer is detected and treated early.

4. Teach breast self-exam. Have the patient give a return demonstration.

5. Discuss indications for mammography and current recommendations for screening mammograms. Patients who have first degree relatives (mother, sister or daughter) with breast cancer are at higher risk and are encouraged to follow a risk-specific mammogram schedule.

6. Discuss the importance of routine annual clinical examination.

WH-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.

2. Discuss the procedure for obtaining follow-up appointments.

3. Emphasize that appointments should be kept.

WH-HY HYGIENE

OUTCOME: The patient will recognize good personal hygiene as an aspect of wellness.

STANDARDS:

1. Review aspects of good personal hygiene such as regular bathing, paying special attention to perineal area. Review the importance of wiping front to back to prevent bacterial contamination of the vagina and urethra.

2. Refer to **WL-HY**.

WH-KE KEGEL EXERCISES

OUTCOME: The patient will understand how to use Kegel exercises to prevent urinary stress incontinence and improve pelvic muscle tone.

STANDARDS:

1. Review the basic pelvic floor anatomy.

2. Define stress incontinence and discuss its causes.

3. Teach Kegel exercises. Encourage frequent practice of Kegel exercises.

WH-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about women's health.

STANDARDS:

1. Provide the patient/family written information about women's health.

2. Discuss the content of the written information with the patient/family.

WH-MP MENOPAUSE

OUTCOME: The patient/family will understand the etiology, symptomatology, and relief measures of menopause.

STANDARDS:

1. Explain that around age 45-55 the normal decline in the levels of estrogen and progesterone signals the start of menopause, the permanent cessation of ovulation and menstruation which results in eventual infertility.

2. Review how fluctuating hormone levels may result in the following physical and emotional symptoms: "hot flashes" (dilation of the blood vessels), headaches, dizziness, tachycardia, breast tenderness, fluid retention, decreased vaginal lubrication, unpredictable mood changes, sleep disturbances, fears about changing sexuality, anxiety and depression. These symptoms are troublesome in approximately 20 percent of menopausal women.

3. Review relief measures which include hormone replacement therapy, vaginal lubricants, reducing salt and caffeine, staying active, and seeking psychological support as necessary.

4. Explain that pregnancy is still a risk and that contraception should be used until there has been no menses for 12 consecutive months.

WH-MS MENSES

OUTCOME: The patient will understand the menstrual cycle.

STANDARDS:

1. Discuss comfort measures for dysmenorrhea.

2. Discuss the importance of good menstrual hygiene. Discuss the use and frequent changing of tampons and napkins. Discourage use of super absorbent tampons.

3. Explain that exercise and sex need not be curtailed during menses but that additional hygiene measures should be taken.

4. Explain that it is normal for menstrual cycles to be irregular for several years after menarche.

WH-N NUTRITION

OUTCOME: The patient will relate diet to health promotion and disease prevention.

STANDARDS:

1. Assess current nutritional habits.

2. Discuss the importance of the food pyramid.

3. Review the relationship of calories to energy balance and body weight.

4. Emphasize the importance of limiting snack foods, fatty foods, red meats, reducing sodium consumption and adding more fresh fruits, fresh vegetables, and fiber to the diet. Emphasize that there is a special need for adequate calcium in the diet. **See OS**

5. Emphasize the necessary component —WATER— in a healthy diet. Reduce the use of colas, coffee and alcohol.

6. Review which community resources exist to assist with diet modification and weight control.

7. Stress the importance of being a smart shopper.

WH-OS OSTEOPOROSIS

OUTCOME: The patient will understand the etiology, symptomatology, prevention and treatment of osteoporosis.

STANDARDS:

1. Discuss the causes of osteoporosis including loss of bone density secondary to reduced estrogen levels and low intake of calcium.

2. Emphasize the importance of prevention. Explain that peak bone density occurs about age 30 and that without intervention, progressive bone loss is typical.

3. Review the risk factors: Low dietary intake of calcium, sedentary lifestyle, familial history, smoking, stress, age over 40, gender, race, stature, and calcium binding medications such as laxatives, antacids, and steroids.

4. Emphasize that treatment is limited to preventing osteoporosis and/or slowing the progression of the disease. It is very important to prevent osteoporosis by a calcium-rich diet, regular weight-bearing exercise, decreased stress, not smoking, reduced alcohol intake, and estrogen replacement as appropriate.

5. Discuss the sequelae including stooped shoulders, loss of height, back, neck and hip pain, and susceptibility to fractures.

WH-PAP PAP SMEAR

OUTCOME: The patient will understand the importance of routine Pap testing after onset of sexual activity or 18 years of age, whichever comes first.

STANDARDS:

1. Explain that the purpose of the Pap test is to screen for precancerous conditions.

2. Emphasize that precancerous conditions of the cervix are highly treatable.

3. Emphasize the importance of routine Pap tests. Encourage the patient to associate the Pap routine with an important date such as her birthday.

4. If this is other than an annual Pap test, explain the reason(s) for the test and the follow-up recommended. Discuss the results of the original test as appropriate.

WH-PMS PREMENSTRUAL SYNDROME

OUTCOME: The patient/family will understand the symptoms and relief measures for Premenstrual Syndrome (PMS).

STANDARDS:

1. Discuss Premenstrual Syndrome. Explain that it is a combination of physical and emotional symptoms resulting from fluctuations in the levels of estrogen and progesterone that occur 5-10 days before the onset of the menstrual period.

2. Review relief measures which include: physical activity, limiting intake of fat and salt, increasing water intake to 8 glasses daily, no limitation of sexual activity, supplemental vitamin B6 or calcium. Diuretics may help relieve some of the symptoms of PMS.

WH-PRO PROCEDURES

OUTCOME: The patient/family will understand the proposed procedure including indications.

STANDARDS:

1. Discuss the indication, risks, and benefits for the proposed procedure.

2. Explain the process and what to expect after the procedure.

3. Emphasize the importance of follow-up care.

WH-RS REPRODUCTIVE SYSTEM

OUTCOME: The patient/family will understand the normal anatomy and physiology of the female reproductive system.

STANDARDS:

1. Review the reproductive anatomy and discuss the reproductive cycle.

2. Discuss the importance of good hygiene.

3. Explain that sexually transmitted diseases can impair fertility (refer to **STD**).

4. Because the risk of cervical cancer is increased by early sexual activity and multiple partners, encourage abstinence or monogamy as appropriate.

WH-STD SEXUALLY TRANSMITTED DISEASES (see codes for STD)

WH-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered.

2. Explain the necessity, benefits, and risks of test(s) to be performed. Explain any potential risk of refusal of recommended test(s).

3. Inform patient of any advance preparation required for the test(s).

What are the Diabetes Curriculum Education Codes?

The Diabetes Education Curriculum Codes are a VERY specific set of codes that follow the new IHS Diabetes Curriculum. They are meant to be used by persons who are familiar with the new IHS Diabetes Curriculum. Mostly this will be diabetes educators, however, if you are another type of provider who is familiar with the new IHS Diabetes Curriculum and knows how to use these specific codes correctly, then please do so. However, if you are not sure about the new IHS Diabetes Curriculum, check with your local Diabetes Program about their use.

Most providers who document diabetes education will want to use the DM codes found in the main set of patient education codes. To go directly to that set of codes click on the words **Diabetes Mellitus.**

DM-ABC **ABC** - KNOWING YOUR NUMBERS

OUTCOME: The individual/family will be able to identify target goals for blood sugar, blood pressure and blood fat levels.

STANDARDS:

ABC1 Verbalize one reason for measuring A1c in blood sugar management.

ABC2 State the target A1c goal for blood sugar control.

ABC3 Identify current A1c.

ABC4 State 3 ways to reach or maintain their A1c goal.

ABC5 Verbalize one reason for measuring B/P.

ABC6 State the target for blood pressure control.

ABC7 Identify current B/P.

ABC8 State three ways to reach or maintain a target B/P.

ABC9 Verbalize one reason for measuring blood fats.

ABC10 Identify at least one current blood fat level.

ABC11 List three ways to prevent or control blood fat levels.

ABC12 State where to get help to improve their numbers.

ABC GS State a plan to reach or maintain at least one of the ABC numbers.

ABC GM Behavior goal met (follow-up)

ABC GNM Behavior goal unmet (follow-up)

DM-AC ACUTE COMPLICATIONS

OUTCOME: The individual/family will understand acute complications and self-care actions to take to prevent or treat acute complications.

STANDARDS:

LOW BLOOD SUGAR

AC1 Define low blood sugar.

AC2 List 2-3 signs and symptoms of low blood sugar.

AC3 Discuss at least 2 causes for low blood sugar.

AC4 State at least 2 action to take when feeling signs and symptoms of low blood sugar.

.

AC5 State at least 2 actions to prevent low blood sugar**.**

HIGH BLOOD SUGAR

AC6 Define high blood sugar.

AC7 List two-three signs and symptoms of high blood sugar.

AC8 State at least two causes for high blood sugar.

AC9 Discuss at least two actions to take when the blood sugar is high.

AC10 State at least two actions to prevent high blood sugar.

SICK DAY

AC11 Explain how the blood sugar is affected during illness.

AC12 State at least 3 things to do when you are sick to manage your blood sugar.

AC13. Identify at least 2 food and drink choices to use when you are sick.

AC GS Write a plan to use for low blood sugar, high blood sugar and sick day management.

AC GM Behavior goal met (follow-up)

AC GNM Behavior goal unmet (follow-up)

DM-BG BEHAVIORAL GOALS (Making Healthy Changes)

OUTCOME: The individual/family will have a basic knowledge of the process of behavior change and goal setting.

STANDARDS:

BG1 State in simple terms what a goal is.

BG2 Discuss personal habits.

BG3 Assist the patient to identify desirable behavioral changes.

BG4 Describe the process for making personal change.

BG GS Write or state a plan to change one or more behaviors.

BG GM Behavior goal met (follow-up)

BG GNM Behavior goal unmet (follow-up)

DM-BGM BLOOD SUGAR MONITORING, HOME

(replaces DM-HM) (remove equip for diabetes)

OUTCOME: The individual/family will understand the importance of blood sugar monitoring, know how to use the monitor and make personal blood sugar monitoring plan.

BGM1 Explain that blood is tested to learn how much sugar is in the blood.

BGM2.List benefits of testing blood sugar.

BGM3 State blood sugar ranges to decrease risk for complications.

BGM4 State personal blood sugar goals.

BGM5 State when to test blood sugar.

BGM6 Demonstrate proper testing of blood sugar. (To include maintenance, support services)

BGM7 Demonstrate how to record results correctly.

BGM8 Discuss benefits of bringing meter and logbooks to clinic visits.

BGM9 State proper disposal of insulin syringes and other sharps.

BGM10 States how to get blood sugar testing supplies.

BGM GS Writes a plan to test blood sugar.

BGM GM Behavior goal met (follow-up)

BGM GNM Behavior goal unmet (follow-up)

DM-CC CHRONIC COMPLICATIONS (Preventing and treating diabetes complication)

Staying Healthy with Diabetes

OUTCOME: The individual/family will understand the prevention and treatment of long-term complications of diabetes.

STANDARDS:

CC1 Discuss that controlling blood sugar lowers the chance of getting diabetes complications.

CC2 Describe the problems that can happen to the blood vessels and nerves when the blood sugar stays high for long period of time.

RETINOPATHY

CC3 Describe retinopathy in their own words.

CC4 List at least 2 ways to prevent or delay eye disease.

CC5 Discuss how eye disease is treated.

HEART DISEASE

CC6 Define heart disease in their own words.

CC7 List at least 2 ways to prevent or delay heart disease.

CC8 Discuss how heart disease is treated.

NEPHROPATHY

CC9 Define nephropathy in their own words.

CC10 List at least 3 ways to prevent or delay kidney disease.

CC11 Discuss how kidney disease is treated.

NEUROPATHY

CC12 Define neuropathy in their own words.

CC13 List 3 ways to prevent or delay nerve damage.

CC14 Discuss ways that nerve damage is treated.(To include pain management)

SEXUAL HEALTH AND DIABETES

CC15 Provide a simple overview of sexual function in men and women.. Encourage the individual to discuss sexual health with an appropriate member of the diabetes team.

CC16 Discuss in simple terms how diabetes and high blood sugars may impact intimacy/sexuality.

CC17 Discuss ways to talk about sexual concerns with significant others and appropriate members of the health care team.

CC18 Identify medical therapies and resources available to help with sexual dysfunction.

PERIODONTAL

CC19 Describe periodontal disease in their own words.

CC20 List at least 3 ways to prevent or delay gum/tooth problems.

CC21 Discuss how periodontal disease is treated.

SUMMARY

CC22 Describe the need for all people with diabetes to get yearly tests, exams, immunizations.

CC23 Identify their risk factors for diabetes complications.

CC GS State at least 1 behavior change that will help lower the risk for diabetes complications.

CC GM Behavior goal met (follow-up)

CC GNM Behavior goal unmet (follow-up)

DM-DP DISEASE PROCESS (What Is Diabetes)

Balancing Your Life and Diabetes

OUTCOME: The individual/family will have a basic understanding of the pathophysiology and symptoms of type 2 diabetes.

STANDARDS:

DP1 Provide a simple definition for diabetes. Encourage the patient to state in his/her own words a definition for diabetes.

DP2 Discuss the differences between type 1 and type 2 diabetes.

DP3 Explain how the body normally uses food.

DP4 List 2 or more risk factors for developing diabetes.

DP5 Describe the impact of insulin resistance in diabetes.

DP6 List one or more signs or symptoms of high blood sugar.

DP7 State the range for normal fasting blood sugar.

DP8 State a normal blood sugar range 1-2 hours after a meal.

DP9 Explain that high blood sugar can cause damage to the nerves and blood vessels in the eyes, heart, kidneys and feet.

DP10 List 4 or more diabetes self care actions necessary for good blood sugar control.

DP GS Choose at least one change to make for diabetes self care.

DP GM Behavior goal met (follow-up)

DP GNM Behavior goal unmet (follow-up)

DM-EX EXERCISE (Moving to Stay Healthy)

OUTCOME: The individual/family will understand the relationship of physical activity in achieving and maintaining blood sugar control by making a personal physical activity plan.

STANDARDS

EX1 List 3 or more benefits of regular physical activity.

EX2 Define physical activity.

EX3 State effects of physical activity on blood sugar.

EX4 Discuss simple ways to measure intensity of physical activity.

EX5 Discuss time and frequency for physical activity.

EX6 Discuss medical clearance issues for physical activity.

EX7 List ways to stay safe during physical activity.

EX GS Write or state a personal plan for physical activity.

EX GM Behavior goal met (follow-up)

EX GNM Behavior goal unmet (follow-up)

DM-FTC FOOT CARE (Taking Care of Your Feet)

OUTCOME: The individual/family will understand the importance of foot care for people with diabetes.

STANDARDS:

FTC1 State the reason for people with diabetes to check their feet every day.

FTC2 Identify the risk factors for foot problems.

FTC3 List 1 daily self care action to prevent foot problems.

FTC4 Describe how to cut toenails correctly.

FTC5 Describe 3 things to look for when choosing proper footwear.

FTC6 State 2 signs and symptoms of foot/skin infections.

FTC7 State when to contact diabetes team about foot problems/infections.

FTC8 State reasons for routine foot exams at each clinic visit and yearly foot screening.

FTC GS Demonstrate a personal foot exam and state a personal foot care plan.

FTC GM Behavior goal met (follow-up)

FTC GNM Behavior goal unmet (follow-up)

DM-IN DIABETES - INSULIN

OUTCOME: The individual/family will understand their insulin regimen.

STANDARDS:

IN1 Discuss how insulin works to control blood sugar in persons with type 2 diabetes.

IN2 Describe the type of insulin they use.

IN3 Identify insulin injection sites.

IN4 Demonstrate proper technique for withdrawing and injecting insulin.

IN5 Discuss proper storage of insulin.

IN6 Discuss proper disposal of insulin syringes and other sharps.

IN7 Discuss the major side effect of insulin shots.

IN8 State how to get insulin refills and supplies.

IN9 Discuss the role of alternative treatments for diabetes and how it affects blood sugar. (To include herbal, traditional healing methods and OTC)

IN GS Write or state personal plan for using insulin.

IN GM Behavior goal met (follow-up)

IN GNM Behavior goal unmet (follow-up)

DM-M DIABETES MEDICATION (Oral pills)

OUTCOME: The individual/family will understand their oral medication regimen.

STANDARDS:

M1 Discuss the role of diabetes medicines in the overall diabetes treatment plan.

M2 State reasons for adding or changing medicines in the treatment plan.

M3 State the importance of testing blood sugar more frequently when medicines are changed.

M4 State the name of their diabetes pills, how much to take, when to take, how it works and possible side effects.

M5 Identify ways to remember to take medicine.

M6 Discuss the side effects of oral pills.

M7 State how to get diabetes medicines refilled.

M8 Discuss the role of alternative treatments for diabetes and how it affects blood sugar.

M9 Discuss the role of alternative treatments for diabetes and how it affects blood sugar. (To include herbal, traditional healing methods and OTC)

M GS Write or state personal plan for taking their oral pills.

M GM Behavior goal met (follow-up)

M GNM Behavior goal unmet (follow-up)

DM-MSE MIND, SPIRIT AND EMOTION

OUTCOME: The individual/family will understand the emotional impact of diabetes on their personal lives.

STANDARDS:

MSE1 Encourage the patient/family to express feelings about having diabetes.

MSE2 Discuss one or more ways diabetes has affected the patient's life and/or the lives of their family members.

MSE3 Identify their support person(s).

MSE4 Encourage the patient/family to share past experiences in dealing with health or other kinds of problems.

MSE5 Explain the body's response to stress.

MSE6 Discuss ways to cope with stress.

MSE GS Identify one way to cope with a personally stressful situation.

MSE GM Behavior goal met (follow-up)

MSE GNM Behavior goal unmet (follow-up)

DM-N NUTRITION (Basics of Healthy Eating)

OUTCOME: The individual/family will understand the basics of healthy eating.

STANDARDS:

N1 State healthy food choices are good for the overall health of the entire family not just for the person with diabetes.

N2 Recognize eating less sugar and fat can help lower blood sugar and reduce weight.

N3 Discuss the major food groups that impact blood sugar levels.

N4 State that portion sizes affect blood sugar.

N5 Show one simple way to determine portion size.

N7 Identify the need to keep a diabetes self-management record.

HEART HEALTH - NUTRITION

N8 Identify foods that increase the risk for heart disease.

N9 Identify foods that can decrease risk for heart disease.

N10 Discuss the different types of fat found in food.

N11 State how to find credible resources for nutrition facts and answers to questions.

N12 Identify possible behavior changes for food choices and heart health.

N GS Make a personal plan to change eating behaviors.

N GM Behavior goal met (follow-up)

N GNM Behavior goal unmet (follow-up)

DM-PPC PRE-PREGNANCY COUNSELING

OUTCOME: The woman with diabetes and her significant other/family will understand the need for blood sugar control prior to pregnancy.

STANDARDS:

PPC1 Discuss the need for blood sugar control before and during pregnancy.

PPC2 State 2 potential problems for baby if pregnancy occurs while blood sugar is high.

PPC3 State pre-pregnancy blood sugar goals.

PPC4 Discuss 3 ways to control blood sugar before pregnancy.

PPC5 State 2 potential problems for mother during pregnancy.

PPC6 Discuss birth control methods to use until ready for pregnancy.

PPC7 State the need for early pregnancy tests.

PPC8 State the need to avoid smoking, alcohol, and drugs before and during pregnancy.

PPC9 Discuss resources available in the community to assist with pregnancy planning.

HIV-PN Describe risk factors for HIV (mother and child) and offer referral for testing.

PPC GS Write a personal pre-pregnancy plan to follow.

PPC GM Behavior goal met (follow-up)

PPC GNM Behavior goal unmet (follow-up)

GDM-BG BEHAVIORAL GOALS (Making Healthy Changes)

OUTCOME: The individual/family will have a basic knowledge of the process of behavior change and goal setting.

STANDARDS:

BG1. State in simple terms what a goal is.

BG2. Discuss personal habits.

BG3. Identify what the patient may want to change.

BG4 Describe the process for making personal change.

BG GS Write one behavior change plan.

BG GM Behavior goal met (follow-up)

BG GNM Behavior goal unmet (follow-up)

GDM-BGM BLOOD SUGAR MONITORING, HOME

OUTCOME: The individual/family will understand the importance of blood sugar monitoring, know how to use the monitor and make personal blood sugar monitoring plan.

STANDARDS:

BGM1 Explain that blood is tested to learn how much sugar is in the blood.

BGM2. List benefits of testing blood sugar.

BGM3 State blood sugar ranges to decrease risk for complications.

BGM4 State personal blood sugar goals.

BGM5 State when to test blood sugar.

BGM6 Demonstrate proper testing of blood sugar. (To include maintenance, support services)

BGM7 Demonstrate how to record results correctly.

BGM8 Discuss benefits of bringing meter and logbooks to clinic visits.

BGM9 State proper disposal of insulin syringes and other sharps.

BGM10 States how to get blood sugar testing supplies.

BGM GS Writes a plan to test blood sugar.

BGM GM Behavior goal met (follow-up)

BGM GNM Behavior goal unmet (follow-up)

GDM-C COMPLICATIONS

OUTCOME: The woman with gestational diabetes and her significant other/family will understand the relationship between high blood sugars and adverse outcomes of pregnancy.

STANDARDS:

C1 Discuss 2 complications for mom if blood sugars are high during pregnancy.

C2 Discuss 2 complications for baby if blood sugars are high during pregnancy.

C3 Describe the how to monitor fetal movement (kick counts).

C4 Discuss how to control blood sugar during pregnancy.

C5 Discuss 2 things she can do to help prevent or control diabetes after delivery.

C GS Write a personal plan to control blood sugar during pregnancy.

C GM Behavior goal met (follow-up)

C GNM Behavior goal unmet (follow-up)

GDM-DP DISEASE PROCESS

OUTCOME: The woman with gestational diabetes and her significant other/family will understand diabetes self care management during pregnancy.

STANDARDS:

DP1 Define in simple terms gestational diabetes.

DP2 State blood sugar goals for pregnancy.

DP3 Describe feelings about diabetes and pregnancy.

DP4 Describe self-care management during pregnancy.

DP GS Write a personal plan for self care management during pregnancy.

DP GM Behavior goal met (follow-up)

DP GNM Behavior goal unmet (follow-up)

GDM-EX EXERCISE (Physical Activity and Pregnancy)

OUTCOME: The woman with gestational diabetes and her significant other/family will have a safe physical activity plan to follow during pregnancy.

STANDARDS:

EX1 Describe a safe physical activity plan for pregnancy.

EX2 List 3 guidelines to follow for a safe exercise program.

EX GS Write a physical activity plan to use during pregnancy.

EX GM Behavior goal met (follow-up)

EX GNM Behavior goal unmet (follow-up)

GDM-FU FOLLOW-UP

OUTCOME: The individual/family will understand the importance of routine follow-up in diabetes treatment and management.

STANDARDS:

FU1 Discuss the importance of regular medical appointments and education to prevent or delay the complications of diabetes.

FU2 States at least 3 standards of diabetes care.

FU3 States the local process to use to make appointments for clinical, education and other services for people with diabetes.

FU GS Writes or states a personal plan for follow-up visits.

FU GM Behavior goal met (follow-up)

FU GNM Behavior goal unmet (follow-up)

GDM-L PATIENT INFORMATION LITERATURE

OUTCOME: The individual/family receives information about diabetes self-care management.

STANDARDS:

L1 Provided with diabetes self-care management information.

L2 Provided information about local resources to promote health.

GDM-N NUTRITION (Meal Planning in Pregnancy)

OUTCOME: The woman with gestational diabetes and her significant other/family will be able to make a personal plan for nutritional needs during pregnancy.

STANDARDS:

N1 Discuss in simple terms carbohydrate foods.

N2 Discuss 2 or more healthy eating changes to control blood sugar during pregnancy

N3 Discuss importance of consistent timing of meals and snacks.

N GS Write a personal plan for making nutrition changes during pregnancy.

N GM Behavior goal met (follow-up)

N GNM Behavior goal unmet (follow-up)

Pain Management (no changes)
Diabetes Tertiary Education
DM-WC Diabetes Wound Care

General Education Codes - Guidelines For Use

These general education codes were developed in response to the ever-expanding list of patient education codes. The following 17 codes are education topic modifiers which can be used in conjunction with any ICD-9 diagnosis to document patient and family education. The following list is NOT exhaustive, nor is it intended to be. If a provider requires more specific education coding the previously developed codes are still available for use and are preferred where applicable.

This newer, more general system is used in essentially the same way as the existing codes, except that instead of having a patient education diagnosis code the provider will simply write out the diagnosis or condition, followed by the education modifier, followed by level of understanding, and finally the provider initials. For example:

Head lice - TX - P - <provider initials>

This would show up on the health summary under the patient education section as:

Head lice - treatment - poor understanding.

If education on more than one topic on the same diagnosis is provided these topics can be separated by commas IF the level of understanding is the same for each topic. For example:

Head lice-P,TX,M,FU-G-<provider initials>.

This would be show up on the health summary under the patient education section as:

Head lice - prevention, treatment, medication, follow-up - good understanding.

If education is provided on multiple diagnoses and/or the level of understanding varies these must be documented separately. For example:

Head lice - P - P - <provider initials>
Head lice - TX - G - <provider initials>
Impetigo - M, FU - G - <provider intials>

This would show up on the health summary under the patient education section as:

Head lice - prevention - poor understanding
Head lice - treatment - good understanding
Impetigo - medications, follow-up - good understanding

Please note that the diagnosis MUST have an associated ICD-9 diagnosis code. These codes must still be documented in the patient education section of the PCC. The levels of understanding have not changed and are **G=good, F=fair, P=poor, R=refused, and Gp=group.**

The committee would like to thank Lisa Hakanson, R.D. for her suggestion that resulted in this addition.

AP - ANATOMY AND PHYSIOLOGY

OUTCOME: The patient and/or family will have a basic understanding of anatomy and physiology as it relates to the disease state or condition.

STANDARDS:

1. Explain normal anatomy and physiology of the system(s) involved.

2. Discuss the changes to anatomy and physiology as a result of this disease process or condition (as applicable.)

3. Discuss the impact of these changes on the patient's health or well-being.

C - COMPLICATIONS

OUTCOME: The patient and/or family will understand the effects and consequences possible as a result of this disease state/condition, failure to manage this disease state/condition, or as a result of treatment.

STANDARDS:

1. Discuss the common or significant complications associated with the disease state/condition.

2. Discuss common or significant complications which may be prevented by compliance with the treatment regime.

3. Discuss common or significant complications which may result from treatment(s).

DP - DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pathophysiology, symptoms and prognosis of his/her illness or condition.

STANDARDS:

1. Discuss the current information regarding causative factors and pathophysiology of this disease state/condition.

2. Discuss the signs/symptoms and usual progression of this disease state/condition.

3. Discuss the signs/symptoms of exacerbation/worsening of this disease state/condition.

EQ - EQUIPMENT

OUTCOME: The patient/family will verbalize understanding and demonstrate (when appropriate) proper use and care of home medical equipment.

STANDARDS:

1. Discuss indications for and benefits of prescribed home medical equipment.

2. Discuss types and features of home medical equipment as appropriate.

3. Discuss and/or demonstrate proper use and care of home medical equipment, participate in return demonstration by patient/family.

4. Discuss signs of equipment malfunction and proper action in case of malfunction.

5. Emphasize safe use of equipment i.e. no smoking around O_2, use of gloves, electrical cord safety, disposal of sharps.

6. Discuss proper disposal of associated medical supplies.

EX - EXERCISE

OUTCOME: The patient/family will have an understanding of the relationship of physical activity to this disease state, condition or to health promotion and disease prevention and develop a plan to achieve an appropriate activity level.

STANDARDS:

1. Explain the normal benefits of a regular exercise program to health and well-being.

2. Review the basic exercise or activity recommendations for the treatment plan.

3. Discuss the relationship of increased exercise or limited physical activity as applicable to this disease state/condition.

4. Assist the patient/family in developing an appropriate physical activity plan.

5. Refer to community resources as appropriate.

FU - FOLLOW UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.

2. Discuss the procedure for obtaining follow-up appointments.

3. Emphasize that appointments should be kept.

HM - HOME MANAGEMENT

OUTCOME - The patient/family will understand the home management of their disease process and make a plan for implementation.

STANDARDS:

1. Discuss the home management plan and methods for implementation of the plan.

2. Explain the importance of following a home management plan, i.e. fewer emergency room visits, fewer hospitalizations, and fewer complications.

3. Explain the use and care of any necessary home medical equipment.

HY - HYGIENE

OUTCOME: The patient will recognize good personal hygiene as an aspect of wellness.

STANDARDS:

1. Discuss hygiene as part of a positive self image.

2. Review bathing and daily dental hygiene habits.

3. Discuss the importance of hand-washing in infection control.

4. Discuss the importance of covering the mouth when coughing or sneezing.

5. Discuss any hygiene habits that are specifically pertinent to this disease state or condition.

LA - LIFESTYLE ADAPTATION

OUTCOME: The patient will strive to make the lifestyle adaptations necessary to prevent complications of the disease state or condition or to improve mental or physical health.

STANDARDS:

1. Review lifestyle aspects/changes that the patient has control over - diet, exercise, safety and injury prevention, avoidance of high risk behaviors, and compliance with treatment plan.
2. Emphasize that an important component in the prevention or treatment of disease is the patient's adaptation to a healthier, lower risk lifestyle.
3. Review the community resources available to assist the patient in making lifestyle changes. Refer as appropriate.

L - PATIENT INFORMATION LITERATURE

OUTCOME - The patient/family will receive written information about the disease process or condition.

STANDARDS:

1. Provide patient/family with written patient information on the disease state or condition.
2. Discuss the content of patient information literature with the patient/family.

M - MEDICATIONS

OUTCOME - The patient/family will understand the goal of drug therapy and be able to demonstrate and explain use of the prescribed regimen.

STANDARDS:

1. Discuss proper use, benefits, common side effects, and common interactions of prescribed medications. Review signs of possible toxicity and appropriate follow-up as indicated.
2. Emphasize the importance of compliance with medication regimen.
3. Discuss the mechanism of action as needed.
4. Emphasize the importance of consulting with a health care provider prior to initiating any new medications, including over-the-counter medications.
5. Emphasize the importance of providing a list of all current medications, including non-prescription or traditional remedies, to the provider.

N - NUTRITION

OUTCOME - The patient will verbalize understanding of the need for balanced nutrition and plan for the implementation of dietary modification if needed.

STANDARDS:

1. Review normal nutritional needs for optimal health.
2. Discuss current nutritional habits. Assist the patient in identifying unhealthy nutritional habits.
3. Discuss nutritional modifications as related to the specific disease state/condition.
4. Emphasize the importance of adherence to the prescribed nutritional plan.

P - PREVENTION

OUTCOME - The patient/family will understand that healthy lifestyle behaviors can reduce the risk of developing diseases, conditions, or complications.

STANDARDS:

1. List lifestyle habits that increase the risk for the onset, progression, or spread of a specific disease/condition.
2. Identify behaviors that reduce the risk for the onset, progression, or spread of a specific disease/condition. i.e.: immunizations, hand washing, exercise, proper nutrition, use of condoms, etc.
3. Assist the patient in developing a plan for prevention.

PRO - PROCEDURES

OUTCOME - The patient/family will understand the proposed procedure, including indications, complications, and alternatives, as well as possible results of non-treatment.

STANDARDS:

1. Discuss the indications, risks, and benefits for the proposed procedure.
2. Explain the process and what to expect after the procedure.
3. Explain the necessary preparation. i.e.: bowel preps, diet instructions, bathing.
4. Discuss pain management as appropriate.
5. Emphasize post-procedure management and follow-up.

S - SAFETY

OUTCOME - The patient/family will understand principles of injury prevention and plan a safe environment.

STANDARDS:

1. Explain that injuries are a major cause of death.
2. Discuss the regular use of seat belts and children's car seats, obeying the speed limit, and avoiding the use of alcohol and/or drugs while in a vehicle.
3. Assist the family in identifying ways to adapt the home to improve safety and prevent injuries. i.e.: poison control, secure electrical cords, fire prevention.
4. Discuss injury prevention adaptations appropriate to the patient's age, disease state, or condition.
5. Identify which community resources promote safety and injury prevention. Provide information regarding key contacts for emergencies, i.e.: 911, Poison Control, hospital ER, police.

TE - TESTING

OUTCOME - The patient/family will have an understanding of the test(s) to be performed including indications and its impact on further care.

STANDARDS:

1. Explain the test ordered.
2. Explain the necessity, benefits and risks of the test to be performed and how it relates to the course of treatment.
3. Explain any necessary preparation for the test, i.e. fasting.
4. Explain the meaning of test results.

TX - TREATMENT

OUTCOME - The patient/family will have an understanding of the possible treatments that may be available based on the specific disease process, test results, and individual preferences.

STANDARDS:

1. Explain that the treatment plan will be made by the patient and medical team after reviewing available options.
2. Discuss the treatment plan including lifestyle adaptations, pharmacologic, surgical, and psychosocial aspects of the treatment plan.
3. Discuss the importance of adhering to the treatment plan, including scheduled follow-up.
4. Refer to community resources as appropriate.

MNT MEDICAL NUTRITION THERAPY (for use by registered dieticians ONLY)

MNT involves the assessment of the nutritional status of patients with a condition, illness, or injury that puts them at risk. Assessment must include review and analysis of medical and diet history, lab values, and anthropometric measurements. MNT is based on assessment, nutrition modalities most appropriate to manage the condition or treat the illness or injury.

MNT plays a key role throughout the continuum of care in all practice settings and phases of the life cycle, from prenatal care to care of the elderly. After nutrition screening identifies those at risk, appropriate MNT leads to improved health outcomes resulting in improved quality of life and cost savings.

The Dietetic Practitioner also referred to, as a Registered Dietitian is the only member of the health care team uniquely qualified to provide MNT.

A Registered Dietitian is defined as an individual with a baccalaureate degree or higher degree in Dietetics or Nutrition, completed a supervised internship and passed the national exam on the Commissioned on Dietetic Registration, which is recognized by the National Commission for Certifying Agencies.